



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE: May 6, 2015**

Larry S. Berger, PHD, Program Director  
Keystone Human Services  
3609 Derry Street  
Harrisburg, Pennsylvania 17101

RE: Keystone Community MH  
1009 Old Noblestown Road  
Oakdale, Pennsylvania 15071  
License #438760

Dear Mr. Berger:

As a result of the Department of Human Services' licensing inspection on April 4, 2014; April 9, 2014; July 10, 2014 and September 19, 2014, of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Larry Mazza" with a stylized flourish at the end.

Larry Mazza  
Regional Licensing Administrator

Enclosure  
Licensing Inspection Summary



APR 9 2015

Violation Report: 43876 - 04/04/2014 - Marini, Michael  
PCH Name: Keystone Community Mental Health

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa. Code §2600

2600.63(d) - A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with their training, unless the resident has a "do not resuscitate" order.

2a. DESCRIPTION OF VIOLATION

At 9:00am on 9-15-14, resident #1 reported he/she did not feel well and that he/she was drowsy. After staff administered Immodium for diarrhea, resident #1 went to his/her room to take a nap. At 12:40pm, staff person A entered resident #1's room. Resident #1 was lying on his/her bed and was cold to the touch and had no pulse. Staff person A immediately called for help, and staff person B arrived and was also unable to find a pulse. At 12:45pm, staff person A called Emergency Medical Services (EMS), and at 12:50pm, staff person C entered the room with an Automated External Defibrillator (AED) at approximately the same time as EMS arrived. EMS was unable to find a pulse and at 1:00pm EMS pronounced the resident dead.

The results of an autopsy conducted by the Office of the Allegheny County Medical Examiner on 9-16-14 indicated resident #1 died as the result of acute bronchopneumonia with clozapine toxicity as a contributing medical factor. The manner of death was accidental.

Staff persons A, B, and C failed to initiate Cardiopulmonary Resuscitation (CPR) or render assistance to resident #1 in accordance with their training. Resident #1 did not have a do not resuscitate order (DNR).

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

- Staff person A stated she was told by the 911 dispatcher to not disturb the body, which is why CPR was not initiated by staff. Keystone attempted to get a transcript of the 911 call but was told the audio recording was no longer in existence and a written transcript can't be obtained.
- At a staff meeting on 9/24/2014, Oakdale staff were re-educated by nursing staff, on CPR procedures when a resident does not have a DNR and that none of the residents at Oakdale have a DNR in place.
- Staff were re-educated again by nursing staff at a staff meeting on 11/26/2014 on DNRs and that CPR must be initiated on all Oakdale residents, since none of the them have DNRs, any time it is deemed medically necessary.
- To prevent future occurrences, the DNR information is emphasized when each staff member receives their initial CPR certification and their annual re-certifications. The LPNs at Crawford Road and Oakdale are certified CPR instructors through the American Red Cross and conduct all of the CPR trainings for staff at Crawford Road and Oakdale. This will allow the Program Director to be sure of the DNR information being emphasized in the trainings.

See page 2A of 2

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page)      Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>5/11/15</u> (Date)	Plan of correction implementation status as of <u>5/11/15</u> (Date)
The above plan of correction was approved by <u>[Signature]</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

MAY 01 2015

Violation Report: 43876 - 04/04/2014 - Marini, Michael  
PCH Name: Keystone Community Mental Health

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.63(d) - A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with their training, unless the resident has a "do not resuscitate" order.

2a. DESCRIPTION OF VIOLATION

At 9:00am on 9-15-14, resident #1 reported he/she did not feel well and that he/she was drowsy. After staff administered Immodium for diarrhea, resident #1 went to his/her room to take a nap. At 12:40pm, staff person A entered resident #1's room. Resident #1 was lying on his/her bed and was cold to the touch and had no pulse. Staff person A immediately called for help, and staff person B arrived and was also unable to find a pulse. At 12:45pm, staff person A called Emergency Medical Services (EMS), and at 12:50pm, staff person C entered the room with an Automated External Defibrillator (AED) at approximately the same time as EMS arrived. EMS was unable to find a pulse and at 1:00pm EMS pronounced the resident dead.

The results of an autopsy conducted by the Office of the Allegheny County Medical Examiner on 9-18-14 indicated resident #1 died as the result of acute bronchopneumonia with clozapine toxicity as a contributing factor. The manner of death was accidental.

Staff persons A, B, and C failed to initiate Cardiopulmonary Resuscitation (CPR) or render assistance to resident #1 in accordance with their training. Resident #1 did not have a do not resuscitate order (DNR).

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Immediately: The administrator or designated staff person shall develop and implement a system to ensure all staff members certified in CPR are immediately updated when a resident's do not resuscitate (DNR) status changes.

Immediately: CPR shall immediately be performed by a staff member certified in CPR for any resident found to be unresponsive without a pulse, unless the resident has a current and valid DNR order. Staff certified in CPR shall be trained on the importance of performing immediate and appropriate action to a resident found unresponsive without a pulse, in accordance with CPR training.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dr. Larry S. Benson Program Director Date 5/1/2015

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The above plan of correction is approved as of \_\_\_\_\_ (Date)

Plan of correction implementation status as of \_\_\_\_\_ (Date)

The above plan of correction was approved by \_\_\_\_\_ (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented